Compliance Evaluation and Review Tool (CERT)

Introduction

The Compliance Evaluation and Review Tool (CERT) was designed to capture provider compliance in the four focus areas listed below. These focus areas capture the intent of IAC 460, article 6 and the Home and Community Based Services (HCBS) waiver applications monitored through the Division of Disability and Rehabilitative Services (DDRS).

I. The provider meets qualifications for waiver services being delivered;
II. The provider has policies and procedures to ensure the rights of individuals, to direct appropriate services, and to support and manage employees;
III. The provider maintains employee information confirming key health, welfare and training issues; and
IV. Quality assurance and quality improvement.

On behalf of the Bureau of Quality Improvement Services (BQIS), Liberty of Indiana surveyors evaluate compliance within these focus areas by reviewing provider documentation guided by the 173 probes. A copy of the CERT Guide utilized through 09/30/2011, including a list of indicators and probes can be found through the following link: http://www.in.gov/fssa/files/BQIS_CERT_-_guide.pdf.

What follows is a summary of results and recommendations from reviews to date. It is hoped that providers will utilize this information to assure alignment of their practices, procedures and files with the outlined regulations/assurances. Providers taking this approach will reduce organizational risk and facilitate a positive review process for those involved.

Results

Through 09/30/2011, 143 CERT reviews have been conducted. Negative findings (i.e., probes that were indicated to not be met) ranged by provider from zero (0) to 89 with an average of 17 negative findings per review. One hundred twenty-eight (128) of these reviews have been closed with the remaining considered in process while corrective action and further review is taken.

There were 37 CERT reviews conducted during the first quarter, FY2012. During this period, 38% of the reviews did not result in a negative finding (Table 1). This improvement (increase from the 25% noted during the previous quarterly period) was accompanied by a reduction in the average number of findings per review (from 14 to 12 over the last two quarters). As can be seen below, there has been a clear trend of improvement noted for providers reviewed in later periods.

Table 1: CERT results across quarterly periods.

	<1/1/11	1/1/11-3/31/11	4/1/11-6/30/11	7/1/11-9/30/11
Reviews Conducted	28	38	40	37
Reviews with Findings	27 (96%)	37 (97%)	30 (75%)	23 (62%)
Range of Findings	0 to 71	0 to 89	0 to 62	0 to 45
Average Findings per Review	21	24	14	12

To explore the areas found to be most frequently unmet, aggregated data across the life of this review process was utilized.

The area with the greatest number of deficiencies continues to be associated with **employee files**: (III) The provider maintains employee information confirming key health, welfare and training issues. Within this area, the following probes were found to be those most frequently out (regulations also provided for reference):

Table 2: Probes related to employee information that were associated with the greatest number of negative findings.

Probe	Number (%) of Providers Out[b]	Change From Last Period[c]
III.A.1.24 - For providers that develop training outcomes and objectives for an individual, do the provider's files contain documentation of **training on appropriate locations for instruction**? 460 IAC 6-14-4(b)(3)	60 (42%)	+11
III.A.1.25 - For providers that develop training outcomes and objectives for an individual, do the provider's files contain documentation of **training on appropriate documentation of an individual's progress on outcomes and objectives**? 460 IAC 6-14-4(b)(4)[a]	55 (38%)	+11
III.A.1.23 - For providers that develop training outcomes and objectives for an individual, do the provider's files contain documentation of **training on completing task analysis**? 460 IAC 6-14-4(b)(2)	54 (38%)	+9
III.A.1.22 - For providers that develop training outcomes and objectives for an individual, do the provider's files contain documentation of **training on selecting specific objectives**? 460 IAC 6-14-4(b)(1)	53 (37%)	+9
III.A.1.18 - Do the provider's employee or agent files contain documentation of **training for each employee/agent on individual rights, including respecting the dignity of an individual**? 460 IAC 6-14-4(a)(1)[a]	48 (34%)	+13
III.A.1.19 - Do the provider's files contain documentation of **training for each employee/agent on individual rights, including protecting an individual from abuse, neglect and exploitation**? 460 IAC 6-14-4(a)(2)	48 (34%)	+10

[a]Probe moved up the list (i.e., more citations during this quarter increased the probe's standing).
[b]Through 09/30/2011, this represents the total number (and percentage) of providers not meeting a particular area.
[c]Number of providers who did not meet this item during the period from 07/01/2011 through 09/30/2011.

It should be noted that five of the six probes have retained their position in this table during this period. When compared with the data reported during the previous communication, two shifts have occurred in this area. With 13 providers found out of compliance in the area of training on individual rights (including respecting the dignity of an individual), this probe was newly added during this quarterly period. If this trend continues (i.e., more negative findings regarding dignity than abuse, neglect and exploitation), the probe that pertains to training on abuse and neglect (III.A.1.19) will likely drop off of this list. The second shift was associated with training on outcomes and objectives. Due to an increase in the number of providers not assuring sufficient training on appropriate documentation of an individual's progress on outcomes and objectives, this probe has further moved up the list from #4 to #2 on this list (i.e., elevation in negative findings).

A high number of providers continue to be found out of compliance in regard to their **policies and procedures** (The provider has policies and procedures to ensure the rights of individuals, to direct appropriate services, and to support and manage employees). While the overall quality and content of these were generally good, the following are noted as areas more frequently in need of improvement (click for example of acceptable documentation).

Table 3: Probes related to policies and procedures that were associated with the greatest number of negative findings.

Probe	Number (%) of	Change From

	Providers Out[b]	Last Period[c]
II.A.4.2 - Does the provider have a **written procedure for informing the individual** on a regular basis as specified by the individual's ISP of the **individual's developmental status**? 460 IAC 6-9-4(b)(2)	38 (27%)	+4
II.A.1.4 - Does the **written procedure for complaints** include methods for informing individuals of the complaint procedure in writing, and in the individual's usual mode of communication? 460 IAC 6-8-3(5)	37 (26%)	+9
II.A.4.3 - Does the provider have a **written procedure for informing the individual** on a regular basis as specified by the individual's ISP of the **individual's behavioral status**? 460 IAC 6-9-4(b)(2)	37 (26%)	+5
II.A.4.1 - Does the provider have a **written procedure for informing the individual** on a regular basis as specified by the individual's ISP of the **individual's medical condition**? 460 IAC 6-9-4(b)(1)[a]	36 (25%)	+4
II.A.10.2 - Does the provider's **policy regarding conflicts of interest** require disclosure of possible conflicts of interest by all of the provider's employees or agents?	33 (23%)	+4

[a]Probe moved up the list (i.e., more citations during this quarter increased the probe's standing).
[b]Through 09/30/2011, this represents the total number (and percentage) of providers not meeting a particular area.
[c]Number of providers who did not meet this item during the period from 07/01/2011 through 09/30/2011.

Three of the top five probes in this area relate to providers informing the individual of their status (i.e., developmental, behavioral, and medical), with the other probe retained from the past quarterly period associated with **conflicts of interest**.

According to 460 IAC 6-3-15.2, "Conflict of interest" means a situation in which an agent, employee, or officer of a provider, or a family member of any of these individuals has a private financial interest, such as affiliation through employment or contract, with an organization that does business with the provider. Without requiring employees to disclose these possible conflicts, waiver participants are at an elevated risk of being financially exploited.

Since the last communication, fewer providers were found lacking a written procedure that ensures the trainer has sufficient education, expertise, and knowledge to achieve the listed outcomes. Because of this, the following area dropped off of this list (Table 3):

- II.A.8.11 - Does the provider's written training procedure include a **system for ensuring that a trainer has sufficient education, expertise, and knowledge of the subject** to achieve the listed outcomes under the system? 460 IAC 6-16-3(b)(3).

This item was replaced by another area that was found to be out of compliance during 25% of provider reviews, **written procedure for complaints**. From the period from 07/01/2011 through 09/30/2011, this probe was found to be the fastest growing deficiency in the area of policies and procedures (9 providers were found to not have this item met).

While most providers reviewed had good systems set up in the area of **quality assurance and quality improvement** (focus area IV of the CERT), there was an overall increase in all of the probes noted as most frequently unmet. Providers had some limitations in the areas of developing and reviewing recommendations to positively impact future practice within the organization. The five (5) areas noted as those not met by the most providers are noted within Table 4 (click for an example of acceptable documentation).

Table 4: Probes related to quality assurance/improvement that were associated with the greatest number of negative findings.

Probe	Number (%) of Providers Out[b]	Change From Last Period[c]
IV.A.1.7 - Does the provider have a **process for reviewing recommendations to assess their effectiveness**? 460 IAC 6-10-10(b)(5)(C)	37 (26%)	+8
IV.A.1.16 - For providers providing **residential habilitation and support services**, does the	33 (23%)	+5

provider have a system **for reviewing the recommendations to assess their effectiveness**? 460 IAC 6-10-10(b)(8)(C)		
IV.A.1.10 - For providers who **administer medication** to individuals, does the provider have a **process for reviewing the recommendations to assess their effectiveness?** 460 IAC 6-10-10(b)(6)(C)	31 (22%)	+7
IV.A.1.3 - Does the provider have evidence of **efforts to improve** services in **response to the annual survey of individual satisfaction**?	25 (17%)	+7
IV.A.1.15 - For providers providing **residential habilitation and support services**, does the provider have a system **for developing recommendations concerning the instructional techniques** used for an individual? 460 IAC 6-10-10(b)(8)(B)	20 (14%)	+3

[a]Probe moved up the list (i.e., more citations during this quarter increased the probe's standing).
[b]Through 09/30/2011, this represents the total number (and percentage) of providers not meeting a particular area.
[c]Number of providers who did not meet this item during the period from 07/01/2011 through 09/30/2011.

Focus Area Section I of the CERT pertains to **provider qualifications** (i.e., the provider meets qualifications for waiver services being delivered). Please note that providers of residential and community based habilitation services must also meet the requirements outlined for transportation (e.g., appropriate driver's license, evidence that vehicles are maintained in good repair, are properly registered, and insured as required under Indiana law). In the event that these requirements are not met the requirements for residential and community based habilitation services are also not met which will result in negative findings. Within this section, the five probes least often met are noted within Table 5 (click for Transportation Qualifications/Requirements).

Table 5: Probes related to provider qualifications that were associated with the greatest number of negative findings.

Probe	Number (%) of Providers Out[b]	Change From Last Period[c]
I.A.2.1 - Does the provider meet the requirements for **transportation** per 460 IAC 6-5-30 and 460 IAC 6-34?	12 (8%)	+3
I.A.23.1 - Does the provider meet the requirements for **residential habilitation and support** per 460 IAC 6-5-24? (& waiver application requirement pg. 70)	11 (8%)	+2
I.A.8.1 - Does the provider meet **community based habilitation - individual** requirements? (waiver application requirement - pg. 104)[a]	8 (6%)	+2
I.A.30.2 - Does the provider have an active **insurance policy that covers loss of life** to an individual? 460 IAC 6-12-2(2)	8 (6%)	+2
I.A.7.1 - Does the provider meet **Community based habilitation -group** requirements? (waiver application requirement - pg. 100)	7 (5%)	+2

[a]Probe moved up the list (i.e., more citations during this quarter increased the probe's standing).
[b]Through 09/30/2011, this represents the total number (and percentage) of providers not meeting a particular area.
[c]Number of providers who did not meet this item during the period from 07/01/2011 through 09/30/2011.

Providers are required to have an active insurance policy that covers loss of life to an individual. While the majority of providers maintain this level of coverage, eight (or 6% of those reviewed) did not. Discovered during reviews, it was not uncommon for "loss of life" to not be captured in the language of a provider's policy. In the majority of these cases, an insurance agent/broker has been able to provide evidence of "loss of life" coverage within other categories such as "bodily harm."

Joint Auditing Process:

Starting April 1, 2011 the Division of Disability and Rehabilitative Services (DDRS) partnered with the Division of Aging (DA) to conduct joint compliance reviews for non-direct ancillary service providers which include providers of:

- Home delivered meals (DA waiver providers only);
- Environmental modifications;
- Vehicle modifications;

- Specialized medical equipment and supplies; and/or
- Personal emergency response systems

As a component of the Compliance Evaluation Review Tool (CERT) surveys, these reviews have focused on compliance with 460 IAC requirements for provider qualifications, criminal background checks, insurance, documentation, and warranty information.

For providers that supply other waiver services besides non-direct ancillary services, the Non-Direct Ancillary Care component of the CERT are conducted at the same time the provider's other waiver services are reviewed. While currently the focus is on combining compliance reviews for non-direct ancillary care providers we are moving in the direction of combining all provider compliance reviews for those providers operating in both DA's and DDRS's waiver programs. The Non-Direct Ancillary component of the CERT utilized through 09/30/2011 can be found at: http://www.in.gov/fssa/files/Provider_Compliance_-_Combined_20110318.pdf.

Through 09/30/2011, there have been a total of 17 combined reviews conducted. For these providers of non-direct care services, 56% of negative findings were associated with employee files. The greatest number of deficiencies was associated with **criminal background checks** (5 of 17 providers did not conduct adequate county checks; 4 of 17 providers did not conduct checks through the Indiana State Police Central Repository). Finally, one of the 17 providers had employed a person that had been convicted of a felony offense.

Recommendations:

What follows is a list of current recommendations associated with the CERT process. For a more complete list, it is recommended that providers also review those noted during the previous two communications. If particular items remains relevant (i.e., noted in the past, still relevant), we have duplicated them within the list below:

1. Based on the results of the CERT Reviews conducted to date, there appears to be a pervasive weakness related to the completion and documentation of staff training (captured in Section III of the CERT, Table 2 above). In fact, around 40% of providers received at least one deficiency in this area. A logical consequence of limited training is lack of program delivery (i.e., implementation). Providers may want to reassess strategies that were previously thought to be ineffective to determine if this was more a result of deficient implementation rather than programming.
2. Providers should examine their policies and procedures as they relate to **conflicts of interest**. The provider's conflicts of interest policy should:
    a. State that situations involving conflicts of interest by an owner, director, agent, employee, contractor, subcontractor or officer performing any management, administrative or direct service to an individual shall be avoided. DDRS Policy: Provider Conflict of Interest, eff. 2-28-11;
    b. Require disclosure of possible conflicts of interest by all of the provider's owners, directors, officers, employees, contractors, subcontractors or agents. DDRS Policy: Provider Conflict of Interest, eff. 2-28-11.

    The presence and execution of a proper conflicts of interest policy will reduce the risk of financial exploitation.
3. Providers should assure that they have conducted adequate criminal background checks of all employees. This would include a check through the Indiana State Police Central Repository and county checks for areas of residence at least three years prior to employment. Subsequent to the

publication of the DDRS Policy: Documentation of Criminal Histories (effective 02/21/2011), providers are also now required to obtain criminal history checks within the counties a potential employee has worked as well as resided for a period of three years prior to conducting the check.

   a. Based on the results from this quarter, this item is particularly relevant for providers of non-direct care services (e.g., personal emergency response systems, specialized medical equipment, and environmental modification).
   b. If a provider determines that an employee has not had a sufficient criminal background check, it is imperative that this be conducted as a priority to assure reduced risk of a potential offense and also assurance that a provider is operating within the scope and practice outlined within both 460 and the relevant DDRS Policy.

4. Providers that maintain multiple office locations should assure that all policies and procedures are consistent. If one location is found to have a policy and procedure that is out of compliance, providers will want to assure that any updated/corrected policies are made available at all of their locations. This will assure both compliance throughout their locations and also consistency of practice.
   a. Any changes to a policy or procedure should also be highlighted through inclusion of a revision date. This will help reviewers confirm that additional locations are maintaining updated and correct policies.
   b. As a note: If reviewers are able to confirm that a provider has consistent policies and procedures across all locations, this allows for a much reduced review of section II of the CERT. For some providers, we have been able to eliminate further review of this section following an initial review, correction and dissemination of updated policies to other locations.
5. Since initiation, 44 providers (or 38%) with at least one negative finding were required to submit a second corrective action plan (CAP). This occurs when either the provider's plan does not address all aspects of a particular finding, or when the CAP does not contain all required components. To increase chances that a CAP will be accepted, providers should assure inclusion of all of the following:
   a. **WHAT:** The CAP will contain the action steps the provider takes to correct the citation. The actions outlined should correct the problem identified in the finding, and when necessary actions to address the same issue in the future.
   b. **HOW:** The CAP will describe the detail and any qualifiers for the actions described in the CAP.
   c. **WHEN:** The CAP will identify timeframes for when the actions will begin and as necessary when the actions will be completed. The date of implementation must contain a reasonable time frame. At a maximum it is expected that implementation of corrections would not exceed 20 business days from the date that you received the CAP acceptance letter.
   d. **WHERE:** The CAP will identify the location where the action(s) will occur when the plan requires an action to occur in a specific location or in more than one place.
   e. **WHO:** The CAP will identify who will be responsible for implementation or completing the actions in the CAP.
6. As a reminder, providers should assure their insurance policies contain reference to the following language:
   a. Personal injury;
   b. Loss of life;
   c. Property damage;
   d. Documentation of Workers Compensation coverage.

If a policy does not contain reference to all aspects noted above, providers should seek confirmation from their insurance company that this is covered or upgrade their policy accordingly. The insurance policy along with any clarification provided through the insurance company will be used to verify proper coverage during the review.

7. To facilitate review of quality assurance (QA) practices (Section IV of the CERT), it is suggested that providers maintain analyses/recommendations/reports for at least two cycles. This will provide further documentation related to implementation of recommendations and insight into a particular providers QA system/process.
8. It is suggested that providers make sufficient preparations for the review. This includes having knowledgeable staff available to assist the surveyor, gathering the necessary documentation for review and even "flagging" particular sections within the policies and procedures as well as employee files. With proper preparation and support, we have found that we can significantly reduce the amount of time necessary to conduct the review and also any frustrations that may be associated with an inability to locate necessary material during the review itself.
    a. Providers should fully review the Announcement Letter and CERT Guide as these provide details about what will be reviewed.
    b. Providers should contact the surveyor if they have any questions. Contact can be made prior to the survey if questions arise during the gathering of material.
9. While we will listen to your concerns, it is important to note that the date of the survey will be set by the surveyor. Unlike other processes that we conduct, the date of this review is not flexible and is intended to allow us to capture provider performance that occurs on a daily basis. If you have extenuating circumstances and would like to further discuss these, it is recommended that you contact Dr. Christopher Baglio at Christopher.Baglio@fssa.in.gov.
10. If providers are having problems with submitting their CAP, it is important that they contact the surveyor prior to the date the CAP is due.
11. It is important that providers sign up to receive the DDRS updates (http://www.in.gov/fssa/ddrs/3894.htm). This will assure providers are aware of the most recent changes that may impact them.
12. The most recent update to the CERT includes the current DDRS policies and procedures (http://www.in.gov/fssa/ddrs/3340.htm). It is important that providers monitor this web site to assure they are able to provide input into the draft policies (http://www.in.gov/fssa/ddrs/4205.htm) as well as update their organization's policies to maintain compliance with requirements. As a reminder, providers are required to follow both 460 IAC Article 6 as well as the DDRS Policies and Procedures.

*As additional reviews are conducted, the overall findings will be re-examined and further recommendations provided.

Future Quality Initiatives

Beginning 10/01/2011, two significant changes have occurred with the CERT: (a) the tool was updated to include the updated DDRS policies and procedures which can be found at http://www.in.gov/fssa/ddrs/3340.htm; and (b) accredited day services (e.g., adult day services, community based habilitation, facility based habilitation, pre-vocational, supported employment, and workplace assistance) were provided "deemed status." As a result, following verification of accreditation, reviewers did not survey these service categories.

The updated version of the CERT can be found on the DDRS/BQIS Web site (http://www.in.gov/fssa/ddrs/2635.htm). Additional updates to the tool included clarification of indicators and probes that are not applicable for solo providers (i.e., provider organizations with only 1 employee

inclusive of the owner/director). While the addition of areas captured within the policies and procedures increased the breadth of the tool, the number of possible citations reduced in number from 174 to 52.

To account for additional time that providers may need to pull together required documentation, BQIS/Liberty of Indiana surveyors will be scheduling CERT reviews 4-5 business days in advance. Attempts will be made to complete reviews in the shortest amount of time possible, which in some instances may be 1-2 days depending on the size of the provider and the organization of the documents.

One final quality initiative currently underway is the clarification of probes/indicators by service category. The result will be a more focused review of documentation relevant to the particular services that are being provided (e.g., behavior management, transportation, etc.). As this is further developed, a copy of this decision making tool will be made available through the DDRS/BQIS Web site.

For more information, please contact:

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Examples of Acceptable Documentation

II.A.4.1 – II.A.4.3

The following is an excerpt from a provider's Individualized Support Plan (ISP) Procedures that contain the required information (making this an acceptable written procedure for probes II.A.4.1 through II.A.4.4):

Each month program staff from each service area (excluding OBRA) and the case coordinator are responsible to monitor the individual's progress of ISP outcomes, continued appropriateness and effectiveness of instructional techniques, overall satisfaction with services, behavioral progress/concerns, health or medical concerns, major life changes and incident reporting (if any) for each person served, and document in a monthly summary report. (OBRA Trainers must complete a semi-annual report)

- *(one point) On a quarterly basis, the case coordinator will meet individually with each person served to discuss the progress of outcomes,* ***current medical condition(s), developmental and behavioral status*** *then make recommendations, accordingly.*

IV.A.3; IV.A.1.7; IV.A.1.10; IV.A.1.15 – IV.A.1.16

The following is an excerpt from a provider's Quality Enhancement Program (QEP) that contains the required information (making this an acceptable written procedure for the listed probes):

Additional data will be ***analyzed and recommendations developed*** *for quality enhancement purposes to include.*

- *The State Management Team will discuss the following at each monthly meeting: Incident reports, Medication Error reports, Medical Issues that require follow up, and State Reportable Incidents*

- *Each month a safety inspection of each program site will be completed by the Safety Committee for that site. Results of the safety inspection and any recommendations will be presented at the monthly State Management Meeting.*
- *All recommendations from the Human Rights Committee will be reviewed at the monthly State Management Meeting and a plan will be developed to address these recommendations. The plan shall be submitted to the Human Rights Committee for review at their next meeting.*
- *The Manager shall be responsible for ensuring that any concerns regarding services provided by other agencies are addressed in a timely manner and reviewed at the monthly State Management Meeting. This would include concerns that other agencies may have with this provider.*
- *Where applicable, the minutes from the Quality Enhancement Council will be reviewed at the State Management Meeting.* ***All recommendations will be addressed at this time (e.g., reviewing the recommendations to assess their effectiveness)*** *and the response will be presented at the next Quarterly Enhancement Council meeting.*
- *Where applicable, the Safety/Quality Committee will also* ***analyze, develop recommendations, and review those recommendations for the appropriateness and effectiveness of the instructional techniques*** *used with the individuals supported. This information will be summarized by the Area Director or Designee from the monthly summaries completed for each individual supported.*

I.A.2.1 – Transportation

The following is an excerpt from the CERT Guide that pertains to the transportation requirements:

The provider will produce:

- *documentation confirming that the provider is one of the following:*
  - *a community mental retardation and other developmental disabilities center; or*
  - *a community mental health center; or*
  - *a child care center licensed pursuant to IC 12-17.2-2-4; or*
  - *otherwise approved to provide a service or services under 460 IAC 6.*
- *certification that any provider employee transporting individuals has the appropriate driver's license (operator's license; chauffeur's license; public passenger chauffeur's license; or commercial driver's license) to drive the type of motor vehicle for which the license was issued.*
- *evidence that all vehicles used by the provider to transport individuals are:*
  - *maintained in good repair;*
  - *properly registered with the Indiana Bureau of Motor Vehicles; and*
  - *insured as required under Indiana law.*
- *documentation of liability insurance for all vehicles owned or leased by the provider to transport individuals covering:*
  - *Personal injury;*
  - *Loss of life; and*
  - *Property damage.*

If the transportation requirements are not met and provider is providing one or more of the following service:

I.A.2.1 – Adult Day Service
I.A.7.1 – Community Based Habilitation – group
I.A.8.1 – Community Based Habilitation – individual
I.A.12.1 – Facility Based Habilitation – individual
I.A.13.1 – Facility Based Habilitation – group
I.A.14.1 – Facility Based Support Services
I.A.23.1 – Residential Habilitation and Support
I.A.27.1 – Supported Employment
I.A.29.1 – Workplace Assistance

The corresponding probe and indicator for these services will not be met. The surveyor can document the finding in the appropriate section as "SEE FINDING FOR I.A.2.1."